

# UNIVERSITY OF HAWAI‘I SYSTEM ANNUAL REPORT



REPORT TO THE 2016 LEGISLATURE

ANNUAL REPORT FROM  
THE HAWAI‘I MEDICAL EDUCATION COUNCIL

HRS 304A-1704

December 2015

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## Introduction and History

In response to the public desire to close the gap of Hawai'i's severe physician workforce shortage with sufficient numbers of well-trained, qualified physicians, the 2003 State Legislature passed into law HRS §304A-1701-1705 and HRS §304A-2164. The University of Hawai'i System (UH) and its John A. Burns School of Medicine (JABSOM) administer these statutes. They consist of three distinct, yet complementary components that work together to assess, strategically plan, advance, and under the right set of circumstances, accelerate the education/training of physicians who will practice in communities throughout Hawai'i. *See excerpted text of statutes in the Appendix A.*

- Component #1 [HRS § 304A-1702] – **Graduate Medical Education (GME) Program**, was established to formally encompass the administration of UH JABSOM's institutional graduate medical education (GME) program.<sup>1, 2</sup>
- Component #2 [HRS §§304A-1703 to 1705] – **Medical Education Council**, was created within UH JABSOM and called "The Hawai'i Medical Education Council" (HMEC). HMEC was given the administrative **duties and powers** to: (1) analyze the State healthcare workforce<sup>3</sup> for the present and future, focusing in particular on the State's need for physicians; (2) assess the State's healthcare training programs, focusing on UH JABSOM's institutional GME enterprise to determine its ability to meet the workforce needs identified by HMEC; (3) recommend to the Legislature and UH Board of Regents (BOR) ways in which identified GME and other healthcare training programs<sup>4</sup> can improve and change in order to effectively meet the HMEC assessment; (4) work with other entities and state agencies, and in consultation with the Legislature and BOR, develop and implement a Plan to ensure the adequate funding of healthcare training programs in the State, with an emphasis on UH JABSOM GME programs; (5) seek funding to implement the funding Plan from all public (county, state and federal government) and private sources; (6) monitor and continue to improve the funding Plan; and, (7) submit an annual report to the Legislature no later than twenty days before the convening of each regular Legislative session.
- Component #3 [HRS §304A-2164] – **Hawai'i Medical Education Special Fund**, the Legislature also passed into law HRS §304A-2164, establishing the "Hawai'i Medical Education Special Fund" into which State and Federal appropriations, and funds from government and private grants, contracts and donations could be deposited and expended for the purposes of UH JABSOM's institutional GME program. The law also designated any money deposits into this fund as *non-lapsing* (i.e., unexpended funds by the end of the fiscal year may be carried forward for future expenditures). This statute was amended by the 2016 legislature via S.B. 160 and the fund terminated as no state monies had been legislated specifically for GME through this fund.

*HMEC Membership* - is comprised of thirteen (13) appointed individuals listed in the Table 1 below. Five members serve ex-officio; eight are Governor-appointed.

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<sup>1</sup> HRS §304A-1701, defines "Graduate Medical Education" or GME as that period of clinical training of a physician following receipt of the medical doctor (or osteopathic doctor) degree and prior to the beginning of an independent practice of medicine.

<sup>2</sup> Ibid, "Graduate Medical Education Program" means a GME program accredited by the American Council on Graduate Medical Education (ACGME). UH JABSOM has maintained full ACGME institutional accreditation.

<sup>3</sup> Ibid, "Healthcare workforce" includes physicians, nurses, physician assistants, psychologists, social workers, etc.

<sup>4</sup> Ibid, "Healthcare training programs" means a healthcare training program that is accredited by a nationally-recognized accrediting body.

TABLE 1 – HMEC CHAIR, MEMBERS AND STAFF						
#	Name	Appointment Dates		Expiration	Term #	Representing
1	Hedges, Jerris (Chair)	Ex-officio			N/A	Dean, UH JABSOM
2	Boland, Mary	Ex-officio			N/A	Dean, UH School of Nursing
3	Brian Issel (Until 5/15) Charles Rosser (8/15 -)	Ex-officio (or designee)			N/A	Designee of the Director, UH Cancer Research Center
4	Magnusson, A. Roy	Ex-officio			N/A	Assoc Dean, UH School of Medicine
5	Virginia Pressler, MD	Ex-officio			N/A	Director, Hawai'i State Dept. of Health
6	Dubbs, William		04/22/2014	06/30/2017	1	Federal Healthcare Sector, VA
7	Hixon, Allen "Chip"		04/22/2014	06/30/2017	1	Health Professional
8	Kajiwara, Gary	04/17/2008	07/01/2012	04/17/2016	2	Teaching Hospital
9	McManus, Vicki	07/01/2012	07/01/2014	06/30/2017	2	General Public/Community
10	Robbins, Kenneth	07/01/2014	07/01/2014	06/30/2017	2	Teaching Hospital
11	Salvador, Darryl	04/23/2009	07/01/2012	06/30/2017	2	Health Professional
12	Vitousek, Sharon	07/01/2012	07/01/2014	06/30/2017	2	Health Professional
13	Yoshioka, Paula		07/01/2012	06/30/2017	1	Teaching Hospital
	Andrade, Naleen	HMEC/GME Administrator			N/A	Professor & DIO/Dir of GME, UH JABSOM
	Borland, Giselle	Administrative Support Staff			N/A	Executive Assistant, UH JABSOM

*HMEC/GME Administrator* – On March 1, 2014, UH JABSOM Dean Dr. Jerris Hedges assigned Dr. Naleen Andrade, UH JABSOM Designated Institutional Official (DIO) and Director of GME, to include HMEC as part of her GME administrative duties.<sup>5</sup> In this role, Dr. Andrade provides HMEC members with the needed administrative coordination and execution of the council's decisions, directives and recommendations. Dr. Andrade's specific duties as the HMEC/GME Administrator are to:

- Work in consultation with HMEC and Dean Hedges to coordinate/implement HMEC duties 2 through 7 previously described under Component #2;
- Integrate the work of HMEC with UH JABSOM's Graduate Medical Education Committee (GMEC);<sup>6</sup>
- Oversee innovation of the Council's collective ideas; and,
- Work with Dean Hedges and UH JABSOM fiscal staff to fully activate the **Hawai'i Medical Education Special Fund** and build its capacity to stabilize and strategically expand GME and healthcare training programs in Hawai'i to meet the healthcare workforce needs.

*Annual Report [HRS§302A-1704]* – The seventh duty of HMEC is to prepare an Annual Report to the Legislature and describe how it has and is fulfilling its duties. This year's HMEC Annual Report is organized into two parts.

Part 1, Activities and Outcomes, describes the salient activities and their outcomes for 2015. Each activity and its outcome are organized under one or more of the pertinent seven (7) HMEC duties.

<sup>5</sup> Dr. N. Andrade served as Professor and Chair of Psychiatry (1995-2012) and officer and director of the American Board of Psychiatry and Neurology (2001-2009). She was appointed UH JABSOM Designated Institutional Official (DIO) & Director of GME on July 1, 2012, following a six-month training/transition period while serving as UH JABSOM Deputy DIO. The DIO is an institutional position created in 1998 by the ACGME to oversee and direct the operations of all GME training programs within an institution. As DIO, Dr. Andrade oversees 10 ACGME-accredited residency (for primary care and other medical specialties); 8 fellowship (for subspecialties) programs; and 2 American Board of Obstetrics & Gynecology (ABOG)-accredited fellowship programs.

<sup>6</sup> The GMEC is chaired by the DIO and is the institutional body that ensures that UH JABSOM's GME training programs maintain substantive compliance and quality with all ACGME accreditation requirements.

Part 2, Recommendations to the Legislature and Board of Regents, provides the reader with the major recommendations HMEC sets forth to continue to develop and enhance the quality and quantity of Hawai'i's healthcare professional workforce, particularly among physicians.

**Part I: Activities and Outcomes – Organized by HMEC Duties**

Meetings & Standing Agenda Items – Three HMEC meetings were convened in 2015 thus far., Agendas and minutes were posted as required for meetings held on January 30, May 8, and August 14, 2015. Below is an overview of the meetings held. Each item provides members with opportunity for strategic brainstorming, synthesis, and development of specific next steps, recommendations, and/or directives to the HMEC/GME administrator.

TABLE 2 – HMEC MEETING AGENDA – STANDING ITEMS & SPECIAL PRESENTATIONS FOR 2014		
Item #	HMEC Agenda Items & Salient Discussion Themes	Presenter(s)
1.	Report from HMEC Chair - Impact/outcomes of key legislation - National trends in Medical Education - HMEC activities & outcomes	Dean J. Hedges
2.	Legislative Highlights - On GME and other healthcare professional training.	Associate Dean A.R. Magnusson & other HMEC members
3.	Report from Dr. Kelley Withy - Hawai'i/Pacific Basin Area Health Education Center (AHEC) Updates - Progress on the <i>Healthcare Workforce Analysis</i> - Updates on Loan Repayment Program, "Practice in Paradise", and other physician and healthcare professional recruitment/retention programs.	Dr. K. Withy
4.	GME Report from Dr. N. Andrade - UH JABSOM GME Programs updates - Progress of HMEC initiatives and directives assigned to her. - UH JABSOM Annual Program Evaluations and Institutional Review	Dr. N. Andrade
5.	Special Presentations by Selected Experts & GME Leaders (listed below by date, topic & speaker:	
	<b>January 30, 2015</b> – Family Medicine Primary Care Consortium and Status of the Family Medicine Residency Program.	Dr. Allen "Chip" Hixon. Dr. Lee Buenconsejo-Lum
	<b>May 8, 2015</b> – Update on Family Medicine Primary Care Consortium and Status of Family Medicine Residency Program.	Dr. Allen "Chip" Hixon. Dr. Lee Buenconsejo-Lum
	<b>May 8, 2015</b> – Updated report on Physician's Healthcare Workforce Assessment – report to the Legislature.	Dr. Kelley Withy
	<b>August 14, 2015</b> – Discussion on approaches to secure funding for GME in the upcoming Legislative Session. Specific issues: Hilo Family Medicine Residency Support, and potential ways to secure funding through Medicaid and matching federal funds.	All Committee Members
	<b>August 14, 2015</b> – Evolving plan for securing funding for the Family Medicine Residency Program should Wahiawa General Hospital be unable to continue the program.	Drs. Hixon, Andrade, and Magnusson

1. Conduct A Comprehensive Healthcare Workforce Analysis

Dr. Kelley Withy and colleagues will be updating their report for the 2016 Legislature, the "Report on Findings from the Hawai'i Physician Workforce Assessment Project". With each passing year since 2009, Withy and colleagues have further refined the survey techniques and methodology that have yielded increasing

levels of specificity (i.e., specialty/subspecialty data) and accuracy (e.g., FTE shortages of practicing physicians for each island) with respect to physician workforce needs. Details of Withy's report will not be presented here; however, some of the salient findings are listed below. *See Withy, K. Report to the 2016 Legislature (Nov. 2015) Findings from the Hawai'i Physician Workforce Assessment Project.*

- Withy's latest workforce assessment methodology was able to focus on the actual full-time equivalents (FTEs) of physicians who actively practice. Therefore, the FTE shortage estimates on all islands are the most accurate and current physician workforce assessments statewide.
- The number of physicians providing patient care in Hawaii decreased by 92 FTE between 2014 and 2015 assessments. Utilizing a new projection model, the estimated current shortage of physicians is 655 FTEs, which indicates a continuing shortage of 20% of physician FTEs statewide. Neighbor islands continue to have the greatest percentage shortage of practicing physicians. Oahu, due to its larger population, has the greatest FTE physician shortage in many specialties including primary care. The unique geography and population distribution in Hawaii makes this an important distinction for health workforce planning.
- The *best case* scenario for practicing physician FTEs in the year 2020 (i.e., 5 years from now) is a shortage of 800 FTEs in comparison to mainland regions with similar demographics.
- Specialty shortages of greater than 30% statewide include: General Surgery, Family Medicine, Orthopaedic Surgery, and Pathology.
- Subspecialty shortages of greater than 30% statewide include: Cardiology, Infectious Disease, Neurology, Neurosurgery, Cardiothoracic Surgery, Colorectal Rectal Surgery, Pulmonology, Rheumatology, Hematology/Oncology, Pediatric Cardiology, Pediatric Endocrinology, Pediatric Hematology/Oncology, and Pediatric Gastroenterology.
- Jobs are available in Hawaii for physicians with 97 positions posted at one point in time this year. This past year, JABSOM did create a process to raise the awareness of job opportunities in Hawaii by JABSOM alumni practicing on the mainland to enhance efforts to recruit physicians to the state.

After Withy & Sakamoto's 2009 study, HMEC recommended and began the implementation of the following measures to address the shortages:

- Initiate the Physician and Health Professionals Loan Repayment Program
- Increase—over 10 years—the UH JABSOM medical student class size by 40%, from 62 to 87 students per class (a total increase of 25 students/class over 10 years).
- Increase—over 10 years—the number of residents/fellows with UH JABSOM GME programs by 40%, from 240 to 336 physicians-in training for primary care and other specialty and subspecialty training. This 96 physician-trainee increase would be focused on specific GME programs (both existing and newly developed programs) in which there are physician FTE shortages of 30% or more; sufficient patient volumes with which trainees are able to apply their knowledge and gain competency/proficiency in clinical skills and reasoning; and, faculty expertise to establish high quality GME training, supervision, and scholarly inquiry in these programs.

## 2. Outcomes of HMEC Workforce Initiatives

- The Loan Repayment Program has been implemented with successful recruitment of both physicians and advanced practice nurses into health care need areas. The greatest ongoing challenge has been the limited state investment needed to optimize federal matching funds.
- UH JABSOM medical student class sizes have had a modest increase from 62 in 2009, to 68 in 2015 and will go to 70 entering students in 2016. Further increases will require additional financial and clinical teaching resources.

- Table 3 below shows the status of the GME positions since 2009. UH JABSOM GME positions went from 241 in 2009, to 221 in 2014. The decrease of 20 positions was due to: decreased funding (down 14 positions) from State and Private sources; and resident attrition (6 positions restored in 2015).
- Despite the overall GME positions decrease, there were gains in the Cardiology training program, which increased its overall three-year class size to 7, and secured private funding to permanently expand to 9 fellows, thereby closing a critical physician shortage gap.<sup>7</sup> Notably the expansion was needed to meet the demand of a surge in patient volume.
- Table 3 also shows an upward trend for positions in calendar years 2015 and 2016 due to the restoration of the 6 positions loss to resident attrition; securing public (state and federal) and private funding to restore some positions lost to funding shortages; securing public and private funding to expand primary care positions in Family Medicine and Internal Medicine; and acquiring funding to establish new fellowships (e.g., Gastroenterology Fellowship).

3. *Conduct Assessment of Hawai'i's Healthcare Training Programs*

UH JABSOM GME Programs – The annual assessment of all UH JABSOM GME programs is conducted at two levels: (1) At the program-level by the Annual Program Evaluation Committees within each residency/fellowship program; and, (2) At the institutional-level by the Graduate Medical Education Committee (GMEC) and the Office of the DIO. DIO Dr. N. Andrade, reports the results of these reviews to HMEC. The 2015 Annual Institutional Review (AIR), which included all Annual Program Evaluations, was completed on September 25, 2015. The AIR reviewed the accreditation status and other GME performance indicators that ensure quality of all programs. The UH JABSOM's Institutional Program and its 20 UH JABSOM GME training programs are fully accredited. Our institution, 9 core residencies, 1 combined residency, and 6 fellowships received ACGME accreditation. Two fellowships (Maternal Fetal Medicine and Family Planning) received accreditation from the American Board of Obstetrics Gynecology (ABOG). The Annual Institutional Review meeting was also used to start a new cycle of strategic planning for GME and a follow up meeting has been scheduled in late October to complete the strategic planning process. The results of these meetings will be presented at the next HMEC meeting and will be used to inform funding requests in the coming year.

TABLE 3 – UH JABSOM GME RESIDENT & FELLOW POSITIONS SINCE 2009 HMEC REPORT.						
UH JABSOM GME PROGRAM	2009 Actual GME Positions	2009 Projected New Positions to Address Shortage	Current Projected Outcomes for Total GME Positions in 2020	2014 Actual GME Positions	2015 Projected GME Positions	2016 Projected GME Positions
<b>Core Residency Programs:</b>						
Family Medicine (FM) <sup>A</sup>	18	18	36	18	18	22
Internal Medicine (IM) <sup>B</sup>	58	9	67	57	58	60
Obstetrics & Gynecology (OB/GYN)	25	0	25	24	25	25
Orthopaedic Surgery (ORTHO)	10	5	15	10	10	10
Pathology (PATH)	10	6	16	9	10	12
Pediatrics (PEDS)	24	0	24	22	24	24
Psychiatry (PSY)	28	0	28	20	23	24
Surgery (SURG)	23	7	30	16	23	24
Transitional – 1 Year (TY)	10	0	10	9	10	10

<sup>7</sup> Withy's Physician Workforce Study (2014) showed Cardiology with a 32.2% shortage. [Shortages 30% or more are considered critical].

Subspecialty Fellowship Programs:						
FM-Sports Medicine (SM)	1	0	1	1	1	1
IM – Cardiovascular Disease (CVD)	6	3	9	7	8	9
IM – Geriatric Medicine (Geri-Med)	10	0	10	9	9	9
OB/GYN – Maternal Fetal Medicine (MFM)	1	3	3	3	3	3
OB/GYN – Family Planning (FP)	n.a.	n.a.	2	2	2	2
PEDS-Neonatal Perinatal (Neo-Peri)	4	0	4	4	2	2
Combined Triple Board (PEDS-PSY-CAP)	4	0	5	0	0	1 (pending GMEC action)
PSY-Addictions Psychiatry (Addict-PSY)	2	2	4	1	1	1
PSY-Child & Adolescent Psychiatry (CAP)	4	2	6	5	6	6
PSY-Geriatric Psychiatry (Geri-PSY)	1	0	1	1	1	1
SURG-Surgical Critical Care	2	0	2	3	3	2
EXISTING PROGRAMS TOTALS	241	55	298	221	237	250
PROPOSED EXPANSION OF EXISTING PROGRAMS & NEW PROGRAMS FOR FY 2016:						
<sup>A</sup> FM – Expansion via FM Primary Care Consortium Rural Track	n.a.	n.a.	18	n.a.	n.a.	6
<sup>B</sup> IM – Gastroenterology (GI)	n.a.	n.a.	6	n.a.	n.a.	1
EXISTING & PROPOSED TOTALS	n.a.	n.a.	322	n.a.	n.a.	257

- GME Programs outside of JABSOM– In addition to the UH graduate medical education programs, HHSC Hilo Medical Center has welcomed their second class of four residents in the Hawaii Island Family Medicine Residency Program. Kaiser Permanente on Oahu has begun the development of a General Internal Medicine Residency Program within their system. Several programs at Tripler Army Medical Center continue to help serve the physician workforce needs of the military community.

4. *Recommendations to the Legislature and UH Board of Regents (BOR) for GME Training Programs*

As required by the ACGME, an Executive Summary of the AIR will be submitted to the BOR in January, after it undergoes its final review and approval by the GMEC on January 2016. Included in the AIR Executive Summary will be the pertinent Action Items that GME leaders have been and will be undertaking to provide changes in continuous improvement of UH JABSOM GME programs and its overall institutional GME program.

In addition to the previous paragraph, this third duty of HMEC involves recommendations to the Legislature and BOR for any changes in or additions to the GME programs. There are two significant changes to report with their accompanying recommendations:

- UH JABSOM Department of Family Medicine & Community Health (DFMCH) Primary Care Consortium – The DFMCH is the clinical department within which the UH JABSOM Family Medicine Residency Program (FMRP) is situated. The faculty members within the DFMCH provide core teaching, supervision and scholarly development of FMRP residents. Both the DFMCH and FMRP have been located at the Wahiawa General Hospital (WGH) and its ambulatory clinic. Due to severe financial adversity at WGH caused by a number of environmental factors beyond the control or capacity of WGH to eliminate, a business plan was proposed to establish a new primary care consortium model supported by UH JABSOM, Hawai'i Pacific Health System (HPH), The Queen's Health System (QHS),



and Hawai‘i Medical Service Association (HMSA). This plan was revised and implemented at the close of 2014.<sup>8</sup>

Ironically, while the State Legislature has appropriated over \$2 million in general funds to the Hilo Medical Center to establish a new, untested Family Medicine Residency Program that will train a total of 12 residents by FY 2017. During the same time frame the legislature did not provide funding to either the UH JABSOM FMRP or Wahiawa General Hospital (WGH), the teaching hospital that has struggled mightily to fund the existing and nationally recognized primary care GME program with cumulatively over 117 graduate physicians.<sup>9</sup>

The DFMCH Family Medicine Primary Care Consortium provides a model within which small rural hospitals like WGH can partner with larger healthcare systems such as HPH and QHS, and HMSA, Hawai‘i’s largest healthcare insurer to: (1) collectively stabilize the GME financial operations that brings quality healthcare to rural areas, and (2) establish the capacity to strategically expand the number of well-trained primary care Family Medicine physicians serving Hawai‘i’s rural communities on all major islands with demonstrated physician shortages.

Over the past year, the Consortium model has been implemented. The Physician’s Center in Mililani is the primary teaching site for the family medicine program and its ownership and operation were transferred to the faculty practice of JABSOM. Because of declining numbers of patients and educational opportunities for the residents at Wahiawa General Hospital, we are making plans to transfer part of the residency to Hawaii Pacific Health hospitals. The Consortium model is being successfully implemented. The final piece is the state funding required to stabilize the program and expand it to neighbor islands. HMEC’s recommendation last year was to provide \$2,000,000 dollars for primary care GME training via the HMEC Special fund to support the Family Medicine Consortium and expand primary care training opportunities. Legislation was introduced during the 2015 session but did not proceed out of committee.

❖ **RECOMMENDATION #1 – UH JABSOM/HMEC continues to recommend that the Legislature appropriate \$2,000,000 for FY 2016 and \$2,000,000 for FY 2017 to match the private funding provided to the DFMCH Primary Care Consortium. This appropriation shall be placed in the Hawai‘i Medical Education Special Fund – note that enabling legislation must also re-establish this Special Fund. HMEC shall work with the DFMCH and FMRP to disburse these funds to maintain the stability of the existing residency program and support the expansion of the FMRP by 4 resident positions and provide the needed faculty, staff and clinical learning environment infrastructure support to sustain this expansion. This appropriation will be an ongoing need to ensure adequate primary care provider training for future generations.**

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<sup>8</sup> *The UH JABSOM DFMCH Business Plan Proposal* (July 2014) and its *Business Plan Addendum* (October 2014) were developed and written by a team of UH JABSOM DFMCH, FMRP, and Office of the DIO leaders in consultation with the WGH CEO.

<sup>9</sup> The UH JABSOM DFMCH and its FMRP were established in 1992 within WGH. Up until this past year, when financial pressures have been rising precipitously, WGH has provided an average of \$2M per year to fund both the DFMCH faculty and FMRP. The UH JABSOM DFMCH is ranked 25<sup>th</sup> out of 130 U.S. allopathic medical schools with departments of FMCH (Reference: American Academy of Family Physicians. *Admissions Guide pp. 6-7.*) Each year, an average of 12% of JABSOM graduates chose to enter this GME program. Over the 23 years since its founding this UH JABSOM Family Medicine GME program has produced 111 family medicine physicians: 52% are graduates of JABSOM; and 14% are Native Hawaiian. Seventy percent (78 of 111) have remained in Hawai‘i to practice and of these, nearly half practice in rural areas on O‘ahu and the neighbor islands.

- B. Internal Medicine Gastroenterology (GI) Fellowship** – An application to establish a 3-year GI Fellowship is being prepared and will be submitted in the fall of 2015 to the ACGME. Withy’s 2014 *Physician Workforce Study* showed Gastroenterology physicians shortage at 15.3%. However, anecdotal reports by practitioners estimate the percent shortage is nearly doubled for patients without health insurance and those insured by Medicaid/Medicare who have significantly reduced access to GI specialists. Private funding for 1 resident per year has been secured. A plan to develop a dedicated UH JABSOM faculty cohort is underway to provide the required clinical and scholarly faculty. It is likely that a future HMEC recommendation to the Legislature and BOR will include a request for faculty and/or staff infrastructure support to augment the private funding to increase the GME positions to 2 fellows per year, along with physician faculty FTE.

5. Rationale for Plan to Ensure Adequate Funding of Healthcare Training Programs

Historically since the mid-1960s, when accredited GME training programs were established in Hawai‘i, funding for residency and fellowship training came from two sources: Teaching Hospitals’ operating funds and Federal GME reimbursements from the Center for Medicaid/Medicare Services (CMS).

- Currently, CMS has approved reimbursement for about 164 resident positions in the teaching hospitals with UH JABSOM GME programs. The number 164 is referred to as the “under-capped positions” set point. This means that all resident/fellow positions above this CMS set point are entirely paid from private funds generated by teaching hospitals’ operating funds, public (State and Federal contracts/grants), and from private foundations.
- Raising the number of CMS under-capped positions can only occur when CMS approves a teaching hospital that does not have an established GME program, to receive new CMS GME reimbursements.<sup>10</sup>
- Presently, CMS GME-direct reimbursements provide about 70% of the total salary for each of the existing 164 UH JABSOM resident positions. Hawai‘i’s teaching hospitals pay the 30% shortfall for these resident positions from their operating budgets.
- The decreasing CMS support for GME combined with the impact of implementing the U.S. Affordable Care Act healthcare reform has placed a financial burden on Hawai‘i’s teaching hospitals that is making it impossible for these institutions to continue to carry this GME burden alone.
- The Family Medicine Primary Care Consortium Business Plan Proposal, described in the previous section, requires matching legislative funding to meet strategically designated physician specialty/subspecialty shortages.

6. Seek Funding for Plan From Public & Private Sources

GME funding from private sources, particularly Hawai‘i’s private teaching hospitals/clinics, has been the established rule for UH JABSOM’s GME Enterprise. The rapidly changing healthcare financial environment, that is limiting the capacity of teaching hospitals/clinics to fund GME training, makes it imperative for the Legislature to create an annual “GME Appropriation” to close the widening gap of physician shortages in Hawai‘i. HMEC recommends that beginning in FY 2016, State government begin to share GME costs with private teaching hospitals/clinics to ensure high quality healthcare for all Hawai‘i citizens.

Hawai‘i State Government has not yet established a dedicated annual GME appropriation to UH JABSOM, its only State University Medical School. This is in contrast to the majority of State-funded University Medical Schools across the U.S. that have dedicated State government appropriations for GME

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<sup>10</sup> Hilo Medical Center (HMC) is an example of a teaching hospital that has applied to CMS for reimbursements for their GME trainee positions. If approved, these CMS funds will support at least 70% of the cost to resident salaries and other GME educational costs now paid by the State.

training programs that have demonstrated community need and limited ability to be financially self-sustaining, such as in the primary care specialties and other specialties/subspecialties located in sparsely populated rural and urban communities on neighbor islands.

Establishing a GME Appropriation that is placed within the Hawai‘i Medical Education Special Fund and overseen by HMEC at this time is financially and strategically sound for the following reasons: (1) Improved accuracy and specificity of Withy’s *Physician Workforce Study* of actual and projected physician needs; (2) Alignment of UH JABSOM and HRP with Hawai‘i’s complex GME system of public/private institutions teaching hospitals/clinics that enhances seamlessness between HMEC and UH JABSOM’s GME Enterprise; and, (3) Development and implementation of the UH JABSOM Family Medicine Primary Care Consortium (see sections 3&4 above) that represents a new approach that provides the Legislative and Executive branches of State Government with an annual GME funding request that is supported by strategic and business plans with programmatic and financial performance outcomes by which the success can be measured. In last years report, the HMEC recommended that a HPSA Survey be conducted to determine the potential for federal funding for training in rural parts of Hawaii. After considerable investigation and discussion with state health officials, it was determined that the survey approach was more extensive that we could fund and the potential benefits were somewhat limited. As a result the HMEC began to explore other options. Most recently we have been in discussion with the new Director of Medicaid Services, within DHS. We believe that the state should look into appropriating funds and securing private funding that could then be matched by federal dollars so that the Medicaid program could generate the financial support needed for GME program going forward.

- ❖ **RECOMMENDATION #2 – UH JABSOM/HMEDC recommends that the 2016 State Legislature establish an annual GME Appropriation to fund designated residency and fellowship programs beyond the primary care initiative noted in Recommendation #1 within the UH JABSOM institutional GME program. The Department of Human Services should explore methods to secure federal matching funds with state Medicaid and perhaps provider funding similar to models currently in place for hospital support. We further recommend that the Legislature reinstate the Hawaii Medical Education Special Fund and place the appropriated dollars in this fund. HMEC shall work with the designated UH JABSOM clinical departments and GME programs to disburse these appropriated funds to achieve the goals, objectives and outcomes outlined in the strategic & financial plans.**

7. Monitor the Implementation and Effectiveness of the Funding Plan

Monitoring the implementation and Effectiveness of the plan defined by Recommendations #1 & #2 will follow a thoughtful evaluation process that assesses the process and outcome objectives associated with GME program operation, GME quality indicators, and financial cost-benefit. The evaluation process is contained in Appendix B.

**Part 2: Recommendations to the Legislature and UH Board of Regents**

HMEC proposes four (4) recommendations to the 2016 Legislature and UH Board of Regents:

- ❖ **RECOMMENDATION #1 – Primary Care Consortium Appropriation. UH JABSOM/HMEC recommends that the Legislature appropriate \$2,000,000 for FY 2017 and \$2,000,000 for FY 2018 to match the private funding provided to the DFMCH Primary Care Consortium. This appropriation shall be placed in the Hawai‘i Medical Education Special Fund. HMEC shall work with the DFMCH and FMRP to disburse these funds to maintain the stability of the existing residency program and support the expansion of the FMRP by 4 resident positions and provide the needed faculty, staff and clinical learning environment infrastructure support to sustain this**

expansion. This appropriation will be an ongoing need to ensure adequate primary care provider training for future generations. *Refer to p. 9-10.*

- ❖ RECOMMENDATION #2 – Annual GME Appropriation to Fund Other Designated GME Programs. UH JABSOM/HMEC recommends that the 2016 State Legislature establish an annual GME Appropriation to fund designated residency and fellowship programs beyond the primary care initiative noted in Recommendation #1 within UH JABSOM's institutional GME program. These appropriation requests are contingent on UH JABSOM GME Strategic & Business Plan Proposals that are reviewed and endorsed by HMEC. The appropriated funds shall be placed within the Hawai'i Medical Education Special Fund. HMEC shall work with the designated UH JABSOM clinical departments and GME programs to disburse these appropriated funds to achieve the goals, objectives and outcomes outlined in the strategic & financial plans. *Refer to pp. 12-13.*
  
- ❖ RECOMMENDATION #3 – Explore Matching Medicaid Appropriations & Provider Assessments. UH JABSOM/HMEC recommends that the 2016 State Legislature amends HRS §304A-1703 – 1704, to include Hilo Medical Center as part of the “Medical Education Council” and “Council Duties”. These amendments would enhance the capacity to focus the strategic and financial planning for all State-funded GME programs. Appropriate allocations for the Hilo Medical Center based Family Medicine Residency Program can be made to the Hawai'i Medical Education Special Fund. *Refer to p. 8-9.*
  
- ❖ RECOMMENDATION # 4 – Restore the Hawaii Medical Education Special Fund. To implement the above recommendations, UH JABSOM/HMEC recommends that the Hawai'i Medical Education Special Fund be re-created and assigned specifically to the UH JABSOM for oversight and allocation.

Respectfully submitted,

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Dean, UH JABSOM and Chair of HMEC  
Professor and Barry & Virginia Weinman Endowed Chair

APPENDIX A – State Statutes Related to HMEC

HRS excerpts below downloaded December 22, 2014 from:

[http://www.capitol.hawaii.gov/hrscurrent/Vol05\\_Ch0261-0319/HRS0304A/HRS\\_0304A-1701.htm](http://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0304A/HRS_0304A-1701.htm)

**CHAPTER 304A  
UNIVERSITY OF HAWAII SYSTEM**

Part I. System Structure

Section

Part IV. Divisions, Departments, and Programs

J. Medical Education Council

- 304A-1701 Definitions
- 304A-1702 Graduate medical education program
- 304A-1703 Medical education council
- 304A-1704 Council duties
- 304A-1705 Council powers

J. MEDICAL EDUCATION COUNCIL

**[§304A-1701] Definitions.** As used in this subpart:

"Centers for Medicaid and Medicare Services" means the Centers for Medicaid and Medicare Services within the United States Department of Health and Human Services.

"Council" means the medical education council created under section [304A-1703].

"Graduate medical education" means that period of clinical training of a physician following receipt of the medical doctor degree and prior to the beginning of an independent practice of medicine.

"Graduate medical education program" means a graduate medical education training program accredited by the American Council on Graduate Medical Education.

"Healthcare training program" means a healthcare training program that is accredited by a nationally-recognized accrediting body. [L 2006, c 75, pt of §2]

**[§304A-1702] Graduate medical education program.** (a) There is created a graduate medical education program to be administered by the medical education council in cooperation with the department of health.

(b) The program shall be funded with moneys received for graduate medical education and deposited into the Hawaii medical education special fund established under section [304A-2164].

(c) All funding for the graduate medical education program shall be nonlapsing.

(d) Program moneys shall only be expended if:

(1) Approved by the medical education council; and

(2) Used for graduate medical education in accordance with sections [304A-1704] and [304A-1705]. [L 2006, c 75, pt of §2]

**[§304A-1703] Medical education council.** (a) There is established within the University of Hawaii, the medical education council consisting of the following thirteen members:

(1) The dean of the school of medicine at the University of Hawaii;

(2) The dean of the school of nursing and dental hygiene at the University of Hawaii;

(3) The vice dean for academic affairs at the school of medicine who represents graduate medical education at the University of Hawaii;

(4) The director of health or the director's designated representative;

(5) The director of the Cancer Research Center of Hawaii; and

(6) Eight persons to be appointed by the governor as follows:

(A) Three persons each of whom shall represent a different hospital at which accredited graduate medical education programs are conducted;

(B) Three persons each [of] whom represent the health professions community;

(C) One person who represents the federal healthcare sector; and

(D) One person from the general public.

(b) Except as provided in subsection (a)(1), (2), (3), and (4), no two council members may be employed by or affiliated with the same:

- (1) Institution of higher education;
- (2) State agency outside of higher education; or
- (3) Private entity.

(c) Terms of office of council members shall be as follows:

- (1) Except as provided in paragraph (2), the dean of the school of medicine, dean of the school of nursing and dental hygiene, vice dean for academic affairs of the school of medicine at the University of Hawaii, and the director of health, or the director's designated representative, shall be permanent ex officio members of the council, and the remaining nonpermanent council members shall be appointed to four-year terms of office;
- (2) Notwithstanding paragraph (1), the governor at the time of the initial appointment shall reduce the terms of four nonpermanent council members to two years to ensure that approximately half of the nonpermanent council members are appointed every two years; and
- (3) If a vacancy occurs in the membership for any reason, the replacement shall be appointed by the governor for the unexpired term in the same manner as the original appointment was made.

(d) The dean of the school of medicine at the University of Hawaii shall chair the council. The council shall annually elect a vice chair from among the members of the council.

(e) All council members shall have voting rights. A majority of the council members shall constitute a quorum. The action of a majority of a quorum shall be the action of the council.

(f) Per diem and expenses incurred in the performance of official duties may be paid to a council member who:

- (1) Is not a government employee; or
- (2) Is a government employee, but does not receive salary, per diem, or expenses from the council member's employing unit for service to the council.

A council member may decline to receive per diem and expenses for service to the council. [L 2006, c 75, pt of §2]

**[§304A-1704] Council duties.** The medical education council shall:

- (1) Conduct a comprehensive analysis of the healthcare workforce requirements of the State for the present and the future, focusing in particular on the State's need for physicians;
- (2) Conduct a comprehensive assessment of the State's healthcare training programs, focusing in particular on graduate medical education programs and their role in and ability to meet the healthcare workforce requirements identified by the council;
- (3) Recommend to the legislature and the board of regents changes in or additions to the healthcare training programs in the State identified by the council's assessment;
- (4) Work with other entities and state agencies as necessary, develop a plan to ensure the adequate funding of healthcare training programs in the State, with an emphasis on graduate medical education programs, and after consultation with the legislature and the board of regents, implement the plan. The plan shall specify the funding sources for healthcare training programs and establish the methodology for funding disbursement. Funds shall be expended for the types of costs normally associated with healthcare training programs, including but not limited to physician salaries and other operating and administrative costs. The plan may include the submission of an application in accordance with federal law for a demonstration project to the Centers for Medicaid and Medicare Services, for the purpose of receiving and disbursing federal funds for direct and indirect graduate medical education expenses;
- (5) Seek funding from public sources, including state and federal government, and private sources to support the plan required in paragraph (4);
- (6) Monitor the implementation and effectiveness of the plan required in paragraph (4), making such modifications as may be required by future developments and changing needs and after consulting with the legislature and the board of regents, as appropriate; and

- (7) Submit a summary report to the legislature no later than twenty days before the convening of each regular session, of the expenditures of program moneys authorized by the council under this subpart. [L 2006, c 75, pt of §2]

**[§304A-1705] Council powers.** The medical education council may:

- (1) Conduct surveys, with the assistance of the department of health and the department of commerce and consumer affairs, to assess and meet changing market and education needs;
  - (2) Appoint advisory committees of broad representation on interdisciplinary clinical education, workforce mix planning and projections, funding mechanisms, and other topics as is necessary;
  - (3) Use federal moneys for necessary administrative expenses to carry out its duties and powers as permitted by federal law;
  - (4) Distribute program moneys in accordance with this subpart; provided that any expenditures authorized shall be for a public purpose and shall not be subject to chapters 42F, 103, 103D, and 103F;
  - (5) Hire employees not subject to chapters 76 and 89 necessary to carry out its duties under this subpart; and
  - (6) Adopt rules in accordance with chapter 91, necessary to carry out the purposes of this subpart. [L 2006, c 75, pt of §2]
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[http://www.capitol.hawaii.gov/hrscurrent/Vol05\\_Ch0261-0319/HRS0304A/HRS\\_0304A-2164.htm](http://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0304A/HRS_0304A-2164.htm)

**[§304A-2164] Hawaii medical education special fund.** There is established a Hawaii medical education special fund, into which shall be deposited all funds received by the medical education council, including:

- (1) Moneys from the federal Centers for Medicaid and Medicare Services or other federal agencies;
- (2) State appropriations; and
- (3) Grants, contracts, donations, or private contributions.

The fund shall be administered by the university. Moneys deposited in the fund shall be expended by the university for the purposes of the graduate medical education program established under section [304A-1702]. [L 2006, c 75, pt of §2]

## APPENDIX B – Evaluation Procedures of Proposed Funding Plan

- I. The Family Medicine Primary Care Consortium Plan will be evaluated in two ways. The first is via the Annual Residency Program Evaluation and Annual Institutional Review previously described. The second evaluation will assess the outcomes of the Consortium Business Plan. Below is an excerpt from pp. 18-19 of the *UH JABSOM DFMCH Business Plan Proposal* that describes the Evaluation of the effectiveness of the Consortium Model:

### Evaluation of Project and Refinement of Consortium Model

*The Consortium should be seen as a work in progress whereby the members are able to use evaluation of the senior managers' abilities to lead the DFMCH faculty physicians and staff to successfully execute the plan of Procedures, Activities and Tasks (PATs). The method of evaluation will be thorough, feasible, and appropriate for the specific aims, PATs, and outcomes of this project. Feedback from this evaluation process will be used to make necessary refinements and changes to the Consortium model and its PATs to ensure successful execution of its planned activities. The primary components are delineated below:*

1. *Evaluation Team & Responsibilities: The project's performance in meeting the specific aims, PATs, and outcomes ... will be evaluated by a seven (7) member Evaluation Team consisting of Dr. Allen "Chip" Hixon, DFMCH Chair, Dr. Lee Buenconsejo-Lum, DFMCH Vice-Chair and FM Residency Program Director, Ms. Shari Tasaka, UCERA Practice Development Officer, Wally Izumigawa, DFMCH Director of Business Affairs, Dr. Jerris Hedges, UH JABSOM Dean, Mr. Don Olden, WGH CEO, and Dr. Roy Magnusson, UCERA Interim CEO.*
2. *Evaluation Plan Design: Each Specific Aim and Major Outcome will be dissected in terms of the following evaluation types:*
  - a. *Process (i.e., activities that must occur for successful completion of the project, such as proper program development/implementation/fidelity, solidified management plans/meetings, timely decision-making, effective logistical support, personnel training/management, fiscal accountability, professional ethics);*
  - b. *Effort (i.e., number of patients who are served and for whom effective measures of quality completion of medical records, billings, coding, etc. are completed);*
  - c. *Effectiveness (i.e., service actually made a positive difference, such as increasing academic cognitive knowledge, skills and attitudes among faculty, residents and staff, hitting the projected outcomes for clinical procedures);*
  - d. *Cost-Benefit Analysis (i.e., overall benefits outweigh the resource/monetary cost of the service).*
  - e. *The following will be completed as part of the Evaluation Plan:*
    - i. *Quarterly: All of the specific aims, PATs and outcomes will be monitored and the progress of each will be conveyed to the DFMCH WGH/PCM faculty and staff by the Evaluation Team. This will assure "real-time" feedback and immediate modifications in the implementation of the project, if necessary. In addition, a quarterly report will be given to the Consortium members by Dr. Hixon, DFMCH Chair. The evaluation reports of Quarters 3 and 4 will be used to plan for the subsequent project year, in addition to establishing the funding levels for that subsequent year.*
    - ii. *End-of-Year: An annual report will be completed at the end of each fiscal year and submitted to the Consortium members. This summative evaluation will be used, along with the quarterly formative evaluation to make the necessary refinements and/or changes to the Consortium model and activities to assure success.*